DATE: [Insert Date]

TO:
[Medical Provider Name]
[Facility Name]
[Address]
[City, State, Zip Code]

RE: MEDICAL RECORDS REQUEST
Patient Name: [Client Full Name]
Date of Birth: [DOB]
Social Security Number: [Last 4 Digits]
Date of Injury: [DOI]
Claim Number: [Claim #]

To Whom It May Concern,

This office represents the above-named individual regarding a Workers' Compensation claim. Please find the enclosed HIPAA-compliant medical authorization signed by our client.

Pursuant to relevant state workers' compensation laws and privacy regulations, please provide a complete and certified copy of all medical records in your possession pertaining to the patient, including but not limited to:

- Initial intake and evaluation reports
- Physician progress notes and narratives
- Diagnostic test results (X-ray, MRI, CT scans, EMG)
- Physical therapy and rehabilitation records
- Operative and surgical reports
- Billing statements and itemized charges
- Work status reports and disability ratings

Please provide these records in electronic format if possible. If there is a fee for the reproduction of these records, please provide an invoice and we will issue payment promptly. If the cost exceeds $[Insert Dollar Amount], please contact our office for authorization before processing.

Thank you for your prompt attention to this request. Please direct all correspondence to the address below.

Sincerely,

[Your Name/Signature]
[Law Firm Name]
[Phone Number]
[Email Address]

Enclosure: Signed Medical Authorization